

EXHIBIT DD
TO JOINT STATEMENT OF
UNDISPUTED FACTS

United National Group**HOME HEALTH CARE /
TEMPORARY STAFFING
APPLICATION**

Return to:

INSTRUCTIONS:

- A. Please type or print clearly. Answer ALL questions completely.
- B. If any question, or part thereof, does not apply, print "N/A" in the space provided.
- C. If more space is needed, continue on a separate sheet of your firm's letterhead, indicating question number.
- D. To this application, please attach copies of
 - Marketing or advertising brochures.
 - Descriptive materials provided to clients.
 - Copy of JCAHO accreditation report, or other similar, if applicable.
 - Other attachments as required in response to application questions.
 - Most current annual financial statement prepared by a CPA.
- E. All materials submitted or required shall be held in confidence.

GENERAL INFORMATION

1. Insured Cirrus
Main Location Address
4651 Charlotte Park Dr, Suite 400, Charlotte, NC 28217 Mecklenburg
Street City State/Zip County
2. Tax Identification Number 56-2274850 Telephone Number (704) 887-3900
3. Years in Business 3.8 yrs. Are you currently enrolled in a PCF? ☒ Yes ☐ No
4. Mailing Address (if different than above)
N/A
Street City State/Zip County
5. List all locations and areas of operations
Above address
Street City State/Zip County
118 W. 6th St, #200 Glenwood Springs, CO 81601 Garfield
Street City State/Zip County

6. Provide names of all legal entities, including subsidiaries desiring coverage. Please provide a description of the entity, percentage owned and date acquired. If applicable, the requested Prior Acts date.

Name	Description	% Owned	Date Acquired	Prior Acts Date
Leslie Climen	OWNER	85%	2/02	2/02
Greg Allen	OWNER	15%	2/02	2/02

7. Within the past 5 years, has applicant acquired, sold or discontinued any operations? ☐ Yes ☒ No

8. Applicant is: ☐ Individual ☒ Partnership ☐ Corporation Other (LLC)

9. Total Annual Gross Receipts (Please attach financial statement prepared by a CPA.) \$ _____

10. Does the applicant provide any overnight bed facilities? ☐ Yes ☒ No

11. Does the applicant perform any treatment or services on the applicant's premises? ☐ Yes ☒ No

COVERAGE REQUESTED

12. Requested Effective Date 1/27/06
(If new venture, please provide owner's resume' and description of related industry experience.)

13. ☒ Professional Liability ☐ Occurrence ☒ Claims Made ☐ Prior Acts Date _____
(Attach copy of prior claims made policy Declarations if requesting prior acts.)

- ☐ \$ 100,000 per Incident / \$ 300,000 Aggregate
☐ \$ 250,000 per Incident / \$ 750,000 Aggregate
☐ \$ 500,000 per Incident / \$ 500,000 Aggregate
☐ \$1,000,000 per Incident / \$1,000,000 Aggregate
☐ \$1,000,000 per Incident / \$2,000,000 Aggregate
☐ \$1,000,000 per Incident / \$3,000,000 Aggregate
☐ \$2,000,000 per Incident / \$4,000,000 Aggregate
☐ \$3,000,000 per Incident / \$5,000,000 Aggregate

14. ☒ General Liability ☒ Occurrence ☐ Claims Made ☐ Prior Acts Date _____
(Attach copy of prior claims made policy Declarations if requesting prior acts.)

Each Occurrence (cannot be excess PL limit) \$ 1,000,000.00
 Medical Expense Limit (Per Person) \$ 5,000.00
 Fire Damage Limits of Liability (Any one Fire) \$ 100,000.00
 Products / Completed Operation Aggregate \$ 1,000,000.00
 General Aggregate (Other than Products) \$ 1,000,000.00

For the next three coverage parts, please input the exposure information on pages 7 and 8.

15. ☒ Non-Owned Auto Liability (General Liability Coverage must be selected)

- ☐ \$ 100,000 per Incident / aggregate
☐ \$ 250,000 per Incident / aggregate
☐ \$ 500,000 per Incident / aggregate
☒ \$1,000,000 per Incident / aggregate

16. ☒ Employee Benefits Liability / Claims Made (General Liability Coverage must be selected)

Each Person \$ 1,000,000
 Total Limit \$ 1,000,000
 Prior Acts Date 6/07/02
 (Attach copy of prior claims made policy Declarations, if applicable.)

17. ☒ Stop Gap Liability (General Liability Coverage must be selected)

Each Person \$ 500,000
 Each Disease \$ 500,000
 Total Limit \$ 500,000

18. Per Claim Deductible

(Same deductible must be selected for both Professional and General Liability.)

- ☐ none ☐ \$1,000 ☒ \$5,000
☐ \$10,000 ☐ \$25,000 ☐ Other _____

19. List Professional Liability policies covering the firm indicated in Question #1 over the past 5 years. If No insurance was in effect for a given year, state "None" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
3rd Current	Nat. Union	HHA604-799	0	6/1/02	\$1M-\$3M	\$2500	\$10,459
2nd Prior	Nat. Union	HHA614-79904	0	6/1/02	\$1M-\$3M	\$2500	\$37,588
Prior	ILL Union	CRL134-914	0	6/1/02	\$1M-\$3M	\$2500	\$36,778
3rd Prior	Infiniti	ASC1000-204	0	6/1/02	\$1M-\$3M	\$2500	\$4,839
4th Prior							

20. List General Liability policies covering the firm indicated in Question #1 over the past 5 years. If No insurance was in effect for a given year, state "None" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.		SAME					
Prior Yr.			AS	8-30-07	1M		
2 nd Prior Yr.					3M		
3 rd Prior Yr.							
4 th Prior Yr.							

CLAIM HISTORY

21. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier? ☐ Yes ☒ No

If YES, please attach information for each claim, suit or incident that includes the following:

- Date of Accident and Date of Notice
- Claimant Name
- Amount Paid or Reserved
- Status – Open or Closed
- Insurance Carrier
- Allegations
- Description of Treatment Rendered.

22. Has any company cancelled, declined or refused to issue similar insurance? ☐ Yes ☒ No

If Yes, please explain:

EMPLOYEES / INDEPENDENT CONTRACTORS

23. Where are employees / independent contractors placed, (by percentage)?

Private Homes 0% Hospitals 100% Nursing Homes 0% Assisted Living 0%
Medical Clinics 0% Doctor's Offices 0% Other (describe) 0%

24. What percentage of clients require:

Pediatric Care 5% Cardiac Care 10% Respiratory Support 10% Infusion Therapy 5%

25. Are any of your employees assigned to temporarily staff the:

Emergency Room

☒ Yes ☐ No

Labor & Delivery Rooms

☒ Yes ☐ No

Intensive Care Units

☒ Yes ☐ No

If Yes, number of staff:

22618

26. Health Care Professionals

<u>Employees/ Contracted Services</u>	<u>Number of Employees</u>	<u>Number of Ind. Contractors</u>	<u>Est. Hours Worked Employees</u>	<u>Est. Hours Worked Contractors</u>	<u>Est. Annual Payroll Employees</u>	<u>Est. Annual Payroll Ind. Contractors</u>
Physical & Respiratory Therapists	0	4	0	160	0	6,722
Nurses Temporary Staffing	1	128	1	4770	1	144,041
Nurses-Other than Temporary Staffing		0		0		0
Nurse Aides / Home Health Aides / Homemakers		0		0		0
Medical Technicians		0		0		0
Pharmacists		0		0		0
Occupational Therapists / Speech & Hearing Therapists		0		0		0
Social Workers		0		0		0
Physician		0		0		0
Physician Assistant / Nurse Practitioner / Clinic Nurse Specialist		2		76		5,762
Live-In Companions		0		0		0
All Others (Describe) <i>Surgical Techs, Pod Techs</i>		33	1	1306		34,591

(Complete job descriptions must accompany this application for those professionals indicated in Q. 26 above.)

27. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations.)

	<u>Ins. Carrier & Effective Date</u>	<u>Policy Limits</u>	<u>State of Licensure</u>	<u>License Number</u>	<u>Employee or Contractor</u>	<u>Hours Per Month</u>
Name - Medical Dir.	N/A	N/A	N/A	N/A	N/A	N/A
Name - Physician	N/A	N/A	N/A	N/A	N/A	N/A
Name - Physician						

HIRING / SCREENING AND EMPLOYMENT PROCEDURES

28. Are employees' / contractors' references contacted before hiring or placement? ☒ Yes ☐ No
 Check all that apply: ☒ Written ☒ Verbal

29. Check all the following that apply if obtained, verified, and filed as part of each employee screening and hiring process:

Applications	<input checked="" type="checkbox"/>	Multi-State Registry	<input checked="" type="checkbox"/>
Drug / HIV / Hep. Testing	<input checked="" type="checkbox"/>	Criminal Background Checks	<input checked="" type="checkbox"/>
Education/Competency	<input checked="" type="checkbox"/>	Licenses/Annual Confirmation	<input checked="" type="checkbox"/>

30. Does applicant question prospects about previous claims or suits? ☒ Yes ☐ No
31. Are employees required to actively participate in continuing education? ☒ Yes ☐ No
32. Does applicant verify any pending license suspensions, revocations?
or pending disciplinary actions? ☒ Yes ☐ No
33. Are professional employees required to carry their own insurance? ☐ Yes ☒ No
 If Yes, what minimum is required? \$ _____
 Are certificates of insurance kept on file? ☒ Yes ☐ No

ACCREDITATION

34. Is applicant a member of?

JCAHO	<input checked="" type="checkbox"/>	National Association of Home Care	_____
CHAP	_____	National League for Nursing	_____
Nat'l Homecare Council	_____	Nat'l Assoc. For Home Care	_____
Nat'l Assoc. of Private Duty	_____	American League for Nursing	_____
Am. Public Health Assoc.	_____	Nat'l Hospice Organization	_____
Other	_____		

35. Is applicant licensed to do business in the states listed above where required? ☒ Yes ☐ No
 Has applicant's license ever been suspended, revoked or restricted? ☐ Yes ☒ No
 (If yes, please provide details). _____

36. Is applicant certified for Medicare reimbursement? ☐ Yes ☒ No

RISK MANAGEMENT

37. What management body oversees the quality of patient care?
(i.e. medical director, advisory board, etc.) Director of Nursing (RN)

Interview Protocol / Credentialing Protocols

38. Do you have a formal written quality assurance and risk management program? ☒ Yes ☐ No
 Person Responsible: Greg Allen Title: President

39. Does applicant participate in any health fairs / health screening? ☐ Yes ☒ No

40. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers. Please explain in an attachment any "No" answers.

- | | | |
|--|---|-----------------------------|
| a. Physician notification in the event of changes in the patient's condition | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Communication to supervisors and team members | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Drug administration procedures | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Medical emergencies | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Daily work reports (Nursing reports, hospital notes, etc.) | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Patient selection / Physician home care treatment plan | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Service discontinuation | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Safe lifting, transferring and ambulating | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Incident reporting (medication errors, patient injury, etc.) | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Sexual / Physical Abuse awareness training | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Advance directives (Living Will) | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Medical equipment training | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Patient's rights | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

CONTRACTUAL AGREEMENTS

41. Does applicant enter into contractual agreements (i.e. hospitals, nursing homes)? ☒ Yes ☐ No

42. Do contractual agreements contain hold harmless or indemnification clauses favorable to the applicant? ☒ Yes ☐ No

43. Is applicant required to name any other entity as an additional insured? ☐ Yes ☒ No
 If so, please list name and address of each entity and the business relationship.

GENERAL LIABILITY

44. Does applicant sponsor any sporting, fundraising or social events? ☐ Yes ☒ No
 Please explain _____

45. Does applicant sell any medical supplies and/or equipment? ☐ Yes ☒ No
 If Yes, Annual Receipts \$ _____

46. Does applicant rent or lease any medical supplies and/or equipment? ☐ Yes ☒ No
 If Yes, Annual Receipts \$ _____

47. Is the applicant named as an additional insured or vendor on the manufacturer's policy for any/all products? ☐ Yes ☒ No

EMPLOYEE BENEFITS LIABILITY

48. Number of total employees 168

49. Average professional turnover 20 % Average non-professional turnover 10 %

50. Employee Benefits provided: ☒ Health ☒ Life ☒ 401K ☒ Section 125

NON-OWNED AUTOMOBILE LIABILITY

51. Are driving records, MVR's checked annually? ☒ Yes ☐ No
52. Estimated annual number of non-medical patient transports 0
53. Are employees required to carry personal auto insurance? ☒ Yes ☐ No
 If Yes, what minimum limit is required? \$ state regulation (monopsony)
 Are certificates of insurance kept on file? ☐ Yes ☒ No

STOP GAP LIABILITY

54. Total Annual Payroll by State: (Monopsony)
- | |
|--------------------|
| ND - \$0 |
| OH - \$ 386,385.06 |
| WA - \$ 113,959.06 |
| WV - \$ 242,582.00 |
| WY - \$ 4483.00 |

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

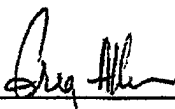
YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands that incorrect or incomplete information could void their protection.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Underwritten by United National Insurance Company, Diamond State Insurance or any members of United National Group.

SIGNATURE OF APPLICANT X  DATE X 1/23/06
(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer: _____

Telephone Number: () _____

Producer's Address:

Street City State/Zip

Tax I.D. Number / New Jersey SL #:

Notice to New York Applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.